Record $7.25 Million Lasik Malpractice Suit Won - A Reminder of the Narrow Boundary Between Refractive Surgery Practice Success and Failure

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This remarkable news broke on the last day of July: The highest-ever award in a Lasik malpractice suit was won by the plaintiff, a former star Wall Street broker and Yale graduate, who claimed he can now only work in his father's security firm after "botched" surgery performed five years ago. The $7.25 million award--$4.5 million for lost wages and $2.75 million for pain and suffering--was handed down by the Manhattan Supreme Court.

Within this record-breaking award, and it's obvious lesson about being extra careful, is embedded a not-so-obvious cautionary tale for every U.S. Lasik surgeon. You must remember as a refractive surgeon that you are bounded on one side by legal barriers represented by the likes of this New York malpractice case, which keeps you from being overly aggressive in case selection. And you are also bounded on the other side by economic barriers represented by the high fixed equipment, staff and marketing costs associated with this subspecialty.

You almost have to have your foot on the brake and the accelerator at the same time. And expanding the automotive analogy, it's a little like driving a 7-foot-wide sports car at 140 miles an hour down a winding, narrow street that's just 85 inches wide. Stray too far left or right and you'll wipe out.

There was once a time when you could be, at least in relative terms, a *casual* refractive surgeon. Twenty years ago, all it took was the following resources:

1. About $50,000 worth of capital equipment (and that was if you got the *good* stuff….remember when the hottest technology argument of the day was whether to use a diamond or sapphire blade?)
2. About $50,000 per year in marketing (because it only cost about $10 to generate a lead.)
3. A tilt-back chair in any one of your lanes (allowing it to become a minor procedure room.)
4. A weekend training course.

And 20 years ago, if you were a cataract surgeon who wanted to begin a radial keratotomy practice, you only needed to perform about 60 cataract cases to earn the $100,000 or so needed for the first full year of operations. Malpractice worries were scant and chased away (at least we thought) by true-false informed consent questionnaires.

In all, unlike the sports car analogy above, the road was wider and straighter, and the speeds were a lot slower.

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Fast forward to 2005. What do you need to become a competent, economically viable refractive surgeon now?

1. About $600,000 worth of capital equipment to start, followed by frequent upgrades.
2. About $300,000 or more per year in marketing (because it now costs about $250 or more to generate a lead.)
3. $100,000 or more in facility upgrades, swank furnishings and cappuccino machines
4. A career-long commitment to mastering what has become a very nuanced subspecialty.

That's a nice, round million dollars…a 10-fold rise in the price of admission. Or is it? At today's cataract reimbursement rates, you would have to perform about 1500 cataract cases to earn the seed capital….using this "cataract currency," the financial cost has gone up by a factor of 25-times. Perhaps, if this recent New York malpractice case is any indication, the legal exposure cost has gone up by at least as much.

With caution in patient selection and clinical protocols, great patient communication and perhaps a liberal dose of personal asset protection, along with a very thick skin, you can manage the legal boundaries that continue to squeeze this branch of eye care. But what about the practical financial and business boundaries?

At any one time I'm working with a number of clients who have a great deal of professional and intellectual zeal for refractive surgery--and often years of fellowship training invested--but who for a variety of failure factors are unable to gain traction. These failure factors can be sorted into five main categories:

1. Too little capital invested…this is not a "field of dreams" environment--you can build it, and they still won't necessarily come unless you promote it. This is the most common program deficit I see in larger general ophthalmology group practice settings where the board is resistant to release the considerable sums needed over many years for external advertising. In a market with a drawing population of one million, it takes $250,000 or more per year to successfully promote to the general public. This hurdle is why some of the fastest start-ups and most-sustained programs depend on optometric comanagement more than on consumer advertising.

2. Too little time invested…if we examine most of the Lasik practices today operating with case volumes that are above the minimum thresholds needs to support the technology, staffing and marketing costs have been involved with refractive surgery for well over a decade--many over two decades. Refractive surgery departments require a much longer development timeline to become economically self-sustaining.

3. Too much capital invested…many otherwise sophisticated practices over-invest in developing a Lasik surgery program, and learn too late that they have developed a program out of scale with the size or composition of their local market.

4. Insufficient surgeon boldness…this is an exquisitely sensitive area. Too bold, and you could end up like the unfortunate New York surgeon. Too reticent, and you'll end up almost as broke with a failed business investment. As a loose rule of thumb, the typical, economically viable Lasik surgeon will find that about 60% or more of his or her patients presenting for a consultation are acceptable candidates for surgery. This figure varies somewhat based on the

source of patients…a cohort of 100 self-referred patients are obviously going to contain fewer operable cases than a cohort of 100 optometrist-referred patients.

5. Too much competition (or too late to enter a crowded market)…as the old marketing ditty goes, "If you are the second competitor to enter the market, you have to spend twice as much to get half the market share." In a given market, two or three Lasik surgeons may prosper while five or six starve.

One or more of these failure factors are present in every faltering refractive surgery program.

Let's enumerate the critical success factors…omitting even one of these can lead to frank program failure, or at least a failure to thrive. Hitting only 70% would be like doing cataract surgery 70% completely…and would result in similarly disappointing results. Here is a list of some of the most important success factors:

- A durable professional zeal for Lasik and other procedures, and a willingness to commit material time and capital resources, long-term, to program development
- Appropriate case selection that is neither too conservative nor too liberal. Depending on the source of patients, this typically means that 60+% of patients who present for consultations are acceptable candidates for some form of vision correction surgery, and that something like a third or more of raw leads eventually come forward to have surgery
- A great product in terms of both outcomes and the patient's subjective impression of the quality and cost-benefit of services
- Significant consumer marketing dollars…at a rate of $15+ per thousand total population in the market
- Consistent, sustained and intelligent advertising; tight response data to be able to discriminate what works and what doesn't.
- Time: Most high-volume surgeons have been at this for 10 or more years
- Risk tolerance for soft numbers and setbacks in early years
- Staying power during downturns (typically associated with recessions and drops in consumer confidence)
- Leading edge (but not bleeding edge) technology adoption
- Conservative projections about the likely market penetration of new procedures
- In a group practice, care in balancing compensation methodologies, so that both success and failure with the Lasik program are absorbed fairly; advance agreement on who is going to do refractive surgery within a group; strong non-compete agreement so that highly successful refractive surgeons within a group practice are not tempted to walk away with their high-profit segment
- Great patient counselors/educators, who more often than not in successful centers receive material bonuses based on case volumes and program success
- ACT! or a similar contact management program used to track leads, cost-per-lead and per-case by source, and to automate the considerable follow-up work
- Not letting patients get lost, but rather, following up appropriately with "fenscesitting" leads, as well as surgical alumni
- An appropriate hedging and balance between refractive and general ophthalmology; in most cases, not shifting to 100% refractive surgery
- An upscale facility…this need not be "Ritz Carlton" in tone, but must be of "Hyatt" grade or higher…and certainly not a "Motel-6" in quality (with apologies, here, to the nice folks at Motel-6)
- A high enough volume to pay for all of this…typically, 100+ cases per month

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